Application For DMR Eligibility

Today's Date: _____

Applicant

Name: _____
first MI Last

Street: _____ Street 2: _____
Apt., P.O. Box, etc.

City: _____ State: _____ Zip Code: _____

Phone: _____ Home ☐ Work ☐ Cell ☐
Include area code and extension

Phone: _____ Home ☐ Work ☐ Cell ☐
Include area code and extension

SS # : _____ Gender: Male ☐ Female ☐

Date of Birth: _____ Primary Language: _____ Interpreter Needed: Yes ☐ No ☐
MM DD YYYY If other than English

Has applicant applied for DMR Eligibility in the past? Yes ☐ No ☐ If yes, in what town? _____ In what year? _____

Referred By (LEA, Agency)

Name: _____ Agency: _____

Street: _____ Street 2: _____
Apt., P.O. Box, etc.

City: _____ State: _____ Zip Code: _____

Phone: _____ Home ☐ Work ☐ Cell ☐
Include area code and extension

email address: _____

Does the individual know you are requesting DMR eligibility on his/her behalf? Yes ☐ No ☐ Comments: _____

Contact Person- Must be completed

Name: _____

Street: _____ Street 2: _____
Apt. P.O. Box, etc.

City: _____ State: _____ Zip Code: _____

Phone: _____ Home ☐ Work ☐ Cell ☐

Phone: _____ Home ☐ Work ☐ Cell ☐

email address: _____

Relationship to Applicant (Check all that apply)	
Parent	☐
Child	☐
Sibling	☐
Spouse	☐
Other Relative	☐
Friend	☐
Guardian	☐
Other	☐

Additional Comments (688, Special Circumstances, emergency, hours you can be reached, etc.)

Return Form to:

Commonwealth of Massachusetts
Department of Mental Retardation

Regional Eligibility Coordinator
(Please refer to attached Protocol.)

For Regional Office Use Only
Date Received by RET
_____

Person Completing Form: _____ Phone: _____
Please Print Important: Include phone #